Unannounced Post-Registration Medicines Management Inspection Report
6 October 2017

Wood Green Nursing Home

Type of Service: Nursing Home
Address: Wood Green, Circular Road, Jordanstown, BT37 0RJ
Tel No: 028 9036 9901
Inspector: Catherine Glover

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 26 beds that provides care for patients living with dementia and old age not falling within any other category

3.0 Service details

Organisation/Registered Provider: Manor Healthcare Ltd **Responsible Individual:** Mr Eoghain King	**Registered Manager:** Mr Tiago Moreira
Person in charge at the time of inspection: Mr Tiago Moreira	**Date manager registered:** 20 March 2017
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category DE – Dementia	**Number of registered places:** 26 comprising: A maximum of 19 patients in category NH-DE and a maximum of 7 patients in category NH-I.

4.0 Inspection summary

An unannounced inspection took place on 6 October 2017 from 09.50 to 14.15.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

The inspection was the first medicines management inspection since the home opened and was to assess if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, the majority of medicine records, storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to records of receipt of medicines, refrigerator temperature records and the auditing process.

Patients were relaxed and comfortable in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mr Tiago Moreira, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an announced variation to registration care inspection undertaken on 13 September 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of incidents: it was ascertained that no incidents involving medicines had been reported to RQIA since the home registered

During the inspection the inspector met with two patients, two registered nurses and the registered manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

A poster informing visitors to the home that an inspection was being conducted was displayed.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 13 September 2017

The most recent inspection of the home was an announced variation to registration care inspection. The QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection

This was the first medicines management inspection to the home.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and appraisals are planned to be completed annually. Competency assessments were completed.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Generally, antibiotics and newly prescribed medicines had been received into the home promptly. A delay in obtaining an antibiotic for one patient was observed and this was discussed with the registered manager who agreed that this would be investigated following the inspection and any necessary learning implemented.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. This safe practice was acknowledged.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. The registered manager was reminded that Schedule 4 controlled drugs must also be denatured.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Two supplies of eye drops were removed from the medicines trolley as the date of expiry could not be determined. This was highlighted to the registered manager. The temperature of one of the medicine refrigerators was not being regularly recorded. There were significant gaps in the temperature record. This should be completed daily to ensure that medicines are being stored at the correct temperature. An area for improvement was identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff, training, competency assessments and the management of medicines on admission.

Areas for improvement

The refrigerator temperature should be monitored and recorded daily to ensure that it remains within the required range of 2^{o}C and 8^{o}C.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome

The sample of medicines examined had been administered in accordance with the prescriber's instructions. Some medicines could not be audited as the date of opening had not been recorded. The recording of dates of opening on all medicines would facilitate the audit process. An area for improvement was identified in relation to the audit process as discussed in Section 6.7.

There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. The reason for and the outcome of administration were mostly recorded.

A care plan was maintained for all but one patient who had been recently prescribed this medicine. The registered nurse advised that the care plan would be completed after the inspection.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that most of the patients could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. A pain assessment is completed as part of the admission process.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the patient's health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included additional records for the administration of transdermal patches. However the records of medicines received into the home were incomplete and should be reviewed. An area for improvement was identified.

Following discussion with the registered manager and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

The registered manager should ensure that a complete record of all medicines received into the home is maintained.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to patients was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible.

It was not possible to discuss medicines with patients however, patients were relaxed and comfortable in the home and good relationships with staff were evident.

None of the questionnaires that were issued were returned within the timescale for inclusion in this report.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

There was evidence that staff listened to patients and relatives and took account of their views

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Written policies and procedures for the management of medicines were in place. They were not examined in detail during this inspection.

There were arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

The registered manager advised that the planned auditing programme had not been completed in recent months. A new deputy manager will be taking up their post in the coming weeks and will have responsibility for completing the medicines audits. The issues identified during this inspection should be resolved by regular monitoring and auditing and it was recommended to the registered manager that the auditing programme should recommence as soon as possible. As stated in Section 6.5, the date of opening should be recorded on all medicines to facilitate the audit process. An area for improvement was identified.

Following discussion with the registered manager and registered nurses it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements. There were clearly defined roles and responsibilities for staff.

Areas for improvement

The registered manager should ensure that medicine management audits are completed regularly.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mr Tiago Moreira, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 6 November 2017	The registered person shall ensure that the refrigerator temperature is monitored and recorded daily to ensure that it remains within the required range of 2^{o}C and 8^{o}C. Ref: 6.4
	Response by registered person detailing the actions taken: Daily audits implemented and spot checks are carried out regularly to ensure compliance
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 6 November 2017	The registered person shall ensure that a complete record of all medicines received into the home is maintained. Ref: 6.5
	Response by registered person detailing the actions taken: Upon receiving medication for the regular monthly cycles, the total amount of tablets is now being recorded on the new MARS to ensure there is an accurate record of all medicines into the home
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 6 November 2017	The registered person shall ensure that medicine management audits are completed regularly. Ref: 6.7
	Response by registered person detailing the actions taken: New deputy manager is in post and these have now started to be carried out regularly.

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